Washington State School for the Blind

Children Aged Birth to 3 with Blindness/Visual Impairment

Registry Form

The purpose of this form is to gather demographic information on the children aged birth to 3 with blindness/visual impairment in the state of Washington. It is not a referral to a particular program nor a request for technical assistance or consultation.

Child' Last Name _____ Child's First Name _____ Date of Birth _____

Parent(s)/Guardian (s) Name _____ Phone Number _____

Address _____ County _____

City _____ Zip Code _____ School District: _____

Visual Impairment Information

_____ Eye report on file with EI agency Date of eye exam: _____ Ophthalmologist's Name: _____

Vision Condition(s):

__ Cortical Visual Impairment (CVI) or Delayed Visual Maturation (DVM)
__ Retinopathy of Prematurity (ROP)
__ Albinism
__ Aniridia
__ Coloboma
__ Leber's Congenital Amaurosis (LCA)
__ Retinal Disorder
__ Nystagmus
__ Optic Nerve Hypoplasia (ONH)
__ Anophthalmia/microphthalmia
__ Cataract
__ Corneal defects
__ Retinoblastoma
__ Glaucoma
__ Strabismus
__ Other: _____

_____ No official VI diagnosis available at this time (no eye report on file) but concerns are present.

Additional Needs and Information

Premature: Yes ____ No _____ Gestational age at Birth: _____weeks
Endocrine Issues: Yes ____ No _____
Seizures: Yes ____ No _____
Hearing Loss: Yes ____ No _____
Dx of a Syndrome: Yes ____ No _____ Name: _____
Additional Disabilities: Yes ____ No _____
Wears glasses/contacts/prosthetics: Please circle

Early Intervention Services

Current IFSP Date (if completed) _____ Name of Agency Providing EI Services _____

Lead FRC or Assigned FRC _____ Email: _____ Phone: _____

Primary EI Provider (if known) _____ Email: _____ Phone: _____

TVI (if known) _____ Email: _____ Phone: _____

Agency providing TVI Service _____

Please submit this form via email to DeEtte.Snyder@wssb.wa.gov or via fax (360)737-2120
Attach Release of Information signed by parent, if required and available.